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5101:3-3-11 Relationship of other covered medicaid services to long-term care facility services.

This rule identifies covered services generally available to medicaid recipients and describes the relationship of such services to those provided by the LTCF. Whenever reference is made to reimbursement of services through the facility cost report mechanism, the provisions governing such reimbursement as set forth in rules 5101:3-3-17 to 5101:3-3-25 of the Administrative Code are applicable.

(A) Dental services.

All dental services, other than personal hygiene services identified in patient assessment standard 2 (reference rule 5101:3-3-31 of THE Administrative Code), provided by licensed dentists and covered under the medicaid program are reimbursed directly to the provider of dental services. Complete or partial dentures cannot be replaced or remade within an eight-year period except for very unusual circumstances.

(B) Laboratory and x-ray services.

Costs incurred in drawing specimens and forwarding specimens to a laboratory are reimbursable through the facility's cost report. All laboratory and x-ray procedures covered under the medicaid program are reimbursed directly to the laboratory or x-ray provider.

(C) Medical supplier services.

Certain medical supplier services are reimbursable to the facility and others directly to the medical supply provider, as follows.

(1) Items which must be reimbursed through the facility's cost report include:

(a) Costs incurred for "needed medical and program supplies" defined as those items which have a very limited life expectancy such as atomizers, nebulizers, bed pans, catheters, electric pads, hypodermic needles, syringes, incontinence pads, and invalid rings.

(b) Costs incurred for "needed medical equipment" (and repair of such equipment), defined as items which can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and are appropriate for use in the facility. Such medical equipment items include hospital beds, wheelchairs, and intermittent positive-pressure breathing machines, except as noted in paragraph (C)(2) of this rule.

(c) Costs of equipment associated with oxygen administration, such as carts, regulators/humidifiers, cannulas, masks, and demurrage.

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(2) Services which are reimbursed directly to the medical supplier provider, subject to applicable prior authorization requirements, include:

(a) Certain durable medical equipment items, specifically, iron lungs, large respirators and associated maintenance services, and custom-made wheelchairs which have parts which are actually molded to fit the recipient.

(b) "Prostheses," defined as devices which replace all or part of a body organ to prevent or correct physical deformity or malfunction, such as artificial arms or legs, electrolarynzes, and breast protheses.

(c) "Orthoses," defined as devices which assist in correcting or strengthening a distorted part, such as arm braces, hearing aids and batteries, abdominal binders, and corsets.

(d) Contents of oxygen cylinders or tanks, including liquid oxygen, except that demurrage is not payable in an LTCF setting.

(e) Oxygen-producing machines for specific use by an individual recipient.

(D) Pharmaceuticals.

Over-the-counter drugs, including compounded drugs other than those for inhalation therapy and allergenic extracts, and dietary supplements are reimbursable through the facility cost report mechanism. All other pharmaceuticals covered under the medicaid program are reimbursable directly to the pharmacy provider, subject to the following conditions:

(1) Drug amounts must be dispensed not to exceed maximum prescription quantities established by the department. Refill authorizations must be recorded on the prescription and are limited to six months or five refills, whichever comes first, except that in order to claim service values in rule 5101:3-3-35 of the Administrative Code, the provisions of that rule must be followed. When new prescriptions are necessary following expiration of the last refill, the new prescription may be ordered only after the physician examines the patient.

(2) A copy of all records regarding prescribed drugs for LTCF patients must be retained by the dispensing pharmacy for at least three years. A receipt for drugs delivered to an LTCF must be signed by the nursing home representative at the time of delivery and a copy retained by the pharmacy. Additional documentation requirements applicable to the facility for medication services are identified in rules 5101:3-3-35 and 5101:3-3-36 of the Administrative Code.

(E) Physical medicine, occupational therapy, speech therapy, and audiology services.

Costs incurred for these services are reimbursable through the patient assessment system and cost-reporting mechanism. No reimbursement for these services is to be made to providers other than the LTCF.

(F) Physician services.

(1) A physician may be directly reimbursed for the following services provided by a physician to a resident of a long-term care facility (LTCF):

(a) All covered diagnostic and treatment services in accordance with Chapter 5101:3-4 of the Administrative Code.

(b) All medically necessary physician visits in accordance with rule 5101:3-4-06 of the Administrative Code.

(c) All required physician visits as described below when the services are billed in accordance with rule 5101:3-4-06 of the Administrative Code.

(i) Physician visits must be provided to a resident of an LTCF and must conform to the following schedule:

~~(a) For skilled nursing facilities, the resident must be seen by a physician at least once every thirty days for the first ninety days after admission, and at least once every sixty days thereafter.~~

(a) ~~(b)~~ For nursing facilities ~~(including intermediate care facilities until October 1, 1990)~~, the resident must be seen by a physician at least once every thirty days for the first ninety days after admission, and at least once every ninety days, thereafter.

(b) ~~(c)~~ A physician visit is considered timely if it occurs not later than ten days after the date the visit was required.

(ii) For reimbursement of the required physician visits the physician must:

(a) Review the resident's total program of care including medications and treatments, at each visit required by paragraph (F)(1)(c)(i) of this rule;

(b) Write, sign, and date progress notes at each visit;

(c) Sign all orders; and

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(d) Personally visit (see) the patient except as provided in paragraph (F)(1)(c)(iii) of this rule.

(iii) At the option of the physician, required visits after the initial visit may be delegated in accordance with paragraph (F)(1)(c)(iv) of this rule and alternate between physician and visits by a physician assistant or nurse practitioner.

(iv) Physician delegation of tasks.

(a) A physician may delegate tasks to a physician assistant or nurse practitioner who:

(i) Meets the applicable definition of section 491.? of the Code of Federal Regulations (CFR);

(ii) Is acting within the scope of practice as defined by state law;

(iv) Is under the supervision and employment of the billing physician.

(b) A physician may not delegate a task when regulations specify that the physician must perform it personally, or when delegation is prohibited by state law or the facility's own policies.

(2) Services directly reimbursable to the physician must:

(a) Be based on medical necessity and requested by the LTCF resident with the exception of the required visits defined in paragraph (F)(1)(c) of this rule; and

(b) Be documented by entries in the resident's medical records along with any symptoms and findings. Each entry must be signed and dated by the physician.

(3) ~~The following services are reimbursable only to an LTCF and may not be directly reimbursed to a physician:~~ SERVICES PROVIDED IN THE CAPACITY OF OVERALL MEDICAL DIRECTION ARE REIMBURSABLE ONLY TO AN LTCF AND MAY NOT BE DIRECTLY REIMBURSED TO A PHYSICIAN.

~~(a) Services provided in the capacity of overall medical direction; or~~

~~(b) The periodic review of a resident's medical records, plan of care, and/or habilitation or rehabilitation plan when provided independently from a physical examination (visit), a diagnostic service or a treatment service. The date of each review must be entered in the resident's medical record or plan of care and any pertinent findings or changes in orders noted. Each entry must be signed and dated by the physician.~~

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(G) Psychologist services.

Costs incurred for the services of a licensed psychologist are reimbursable through the patient assessment system and cost-reporting mechanism. No reimbursement for such services can be made to a provider other than the LTCF or a community mental health center certified by ODMH.

(H) Respiratory therapy services.

Costs incurred in the physician-ordered administration of aerosol therapy which is rendered by a registered respiratory therapist are reimbursable through the patient assessment system and cost-reporting mechanism. No reimbursement for such services can be made to a provider other than the LTCF.

(I) Transportation services.

Costs incurred by the facility for transporting patients by means other than ambulance or ambulette are reimbursable through the facility cost-reporting mechanism. Payment is made directly to authorized providers for covered ambulance and ambulette services.

(J) Vision care services.

All covered vision care services, including examinations and dispensing and fitting of eyeglasses, are reimbursed directly to authorized vision care providers in accordance with Chapter 5101:3-6 of the Administrative Code.

(K) Podiatry services.

Covered services provided by licensed podiatrists are reimbursed directly to the authorized podiatric provider. Payment by the department is limited to one visit per month for patients in an LTCF setting.

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5101:3-3-12 Resident review process: general provisions.

(A) This rule provides an overview of the resident review process in terms of its purpose, underlying concepts, and design. The resident review process is designed to:

(1) Identify what services are needed by LTCF residents and what services are delivered by the LTCF in order to determine reimbursement for the delivery of needed services and/or to apply a disallowance for services needed by a resident, but not delivered. Rules 5101:3-3-19 ("CEILINGS ON CERTAIN COSTS ACCOUNTS") and 5101:3-3-23 ("NONALLOWABLE COSTS") of the Administrative Code detail the fiscal provisions which are designed to recognize an LTCF's cost for improving and maintaining a resident's physical condition at its optimum, while conversely not rewarding facilities for keeping residents in a more dependent state.

(2) Accomplish certain utilization control activities, specifically utilization review and inspections of care. Rules 5101:3-3-14 ("RESIDENT REVIEW PROCESS") and 5101:3-3-15 ("UTILIZATION CONTROL") of the Administrative Code detail these activities.

(3) Provide overall mechanisms to assure that each resident receives needed services and to identify the facility's capacity and performance in delivering needed services.

(B) The assessment of the individual needs of each medicaid resident and the services delivered to each resident will be made according to the provisions contained in rules 5101:3-3-30 ("BEHAVIOR/MENTAL, STANDARD 1") to 5101:3-3-45 ("PSYCHOSOCIAL, STANDARD 15-5") of the Administrative Code.

(1) The review process will be conducted by professional personnel employed by the department who will review the services needed and received by each medicaid resident during preceding month(s). The review will cover the preceding three months of services needed and services delivered, unless otherwise agreed upon by the LTCF and the ~~department~~ CHIEF, DIVISION OF LONG-TERM CARE, OR APPOINTED DESIGNEE.

(2) No review will be made of residents who have not made application for medicaid.

(3) The determination of the needs of the resident will be based upon the resident's plan of care, medical records, program notes, physician orders, and observation of the resident AS SPECIFIED IN RULE 5101:3-3-14 ("RESIDENT REVIEW PROCESS") PARAGRAPHS (B)(5)(a) AND (B)(5)(b) OF THE ADMINISTRATIVE CODE.

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(4) The determination of the services delivered to each resident will be based upon the medical records, nursing notes, program notes, and observation of the resident AS SPECIFIED IN RULE 5101:3-3-14 ("RESIDENT REVIEW PROCESS") OF THE ADMINISTRATIVE CODE.

(5) The services needed and delivered will be recorded on a departmental form which will be forwarded to the department's central office. Each service unit has a value in terms of dollars used to establish a ceiling and in terms of minutes used to determine a facility's capacity to deliver services.

(C) The review of services needed and services delivered will be made according to the standards contained in rules 5101:3-3-30 ("BEHAVIOR/MENTAL, STANDARD 1") to 5101:3-3-49 ("PSYCHOSOCIAL, STANDARD 15-5") of the Administrative Code.

(1) Fourteen standards represent the known measurable services delivered on a routine basis to long-term care residents. Not all services within the fourteen standards are necessarily delivered to each resident. Within each service standard are categories which represent different frequencies of delivery and which may require different levels of professional expertise. Each category represents a range of service delivery (e.g., two to twenty-five injections per month).

(2) Five basic types of habilitation services represent measurable services delivered to long-term care residents who can benefit from them. These are delivered by medical specialists (e.g., a LICENSED physical therapist) for limited periods of time.

(3) All the standards used in the resident review process are detailed in rules 5101:3-3-30 ("BEHAVIOR/MENTAL, STANDARD 1") to 5101:3-3-49 ("PSYCHOSOCIAL, STANDARD 15-5") of the Administrative Code. Each standard contains:

(a) A description of the standard, written in specific objective and measurable terms;

(b) Specific requirements for the type of documentation that must be maintained by the LTCF to establish a medical audit trail;

(c) Service units which reflect the range or frequency of services within each service category; and

(d) Identification of any edits applicable to the standard. For example, no resident can receive more than one service unit within a particular standard. In addition, some service standards cannot be presented concurrently.

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(D) Each unit or category of service within a standard has a predetermined dollar value based on a formula of time necessary to perform a service (paragraph (C) of rules 5101:3-3-30 ("BEHAVIOR/MENTAL, STANDARD 1") to 5101:3-3-43 ("INTRAVENOUS AND SUBCUTANEOUS FLUIDS, STANDARD 14") and 5101:3-3-45 ("SPECIALIZED SERVICES, STANDARD 15-1") to 5101:3-3-49 ("PSYCHOSOCIAL, STANDARD 15-5"), and paragraph (E) of rule 5101:3-3-45 ("SPECIALIZED SERVICES, STANDARD 15-1") of the Administrative Code) multiplied times the skill level of the professional generally considered capable of rendering that service (rule 5101:3-3-23 ("SKILLED LEVEL OF PROFESSIONALS NECESSARY TO RENDER SPECIFIC SERVICES") of the Administrative Code).

(1) The "time allocated" is the time necessary to deliver the services at the upper end of the range of services covered by the category (excluding the extremes). The purpose of using the upper end is the fact that the dollar value represents a ceiling of reimbursable costs, rather than a prospective rate. Since the facility's ceiling is based upon the total of all medicaid residents' needs, any over- or under-recognition of costs by the service unit (which is at the upper end of the services) as it relates to a specific resident is compensated by averaging. However, dividing each standard into service units recognizes costs of delivering more costly services if needed by the resident and avoids structuring a system that rewards keeping a resident at a more dependent level. The time allocated includes all activities directly connected with a particular service unit including:

(a) Carrying out the specific procedures contained in rules 5101:3-3-30 ("BEHAVIOR/MENTAL, STANDARD 1") to 5101:3-3-49 ("PSYCHOSOCIAL, STANDARD 15-5") of the Administrative Code and/or assisting the physician with the specific procedures;

(b) Conversing or exchanging pleasantries with the resident during service delivery (e.g., listening to requests/wishes/complaints), teaching simple activities of daily living, and providing interpretations to the resident of the care being provided;

(c) Observing the physical condition/behavior of the resident, and evaluating the resident's need for care;

(d) Preparation and immediate aftercare of equipment (e.g., medication and treatment trays), travel time (e.g., from nurse's station to the resident's room, or escorting the resident to service delivery site), and reading or performing simple laboratory tests (e.g., blood counts and urine testing); and

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(e) Maintaining the resident's records (e.g., checking physician orders and charting the care given).

(2) An allowance is added to the actual time necessary to render the services referenced in paragraph (D)(1) of this rule. Not all service units within each service standard are assigned the same weighting factor. As a matter of public policy, some standards and some service units within a standard will be reimbursed on the basis of the time necessary to render the service (without an additional allowance) in order to prevent structuring a system that would inadvertently promote the delivery of services that foster dependence of the resident on institutional services. The additional allowance is for items not measured by the resident review process and includes:

(a) Indirect allocation of the nonmeasurable nursing and habilitation services, e.g., the information exchange regarding the resident's condition; participation in physician rounds; ordering specific drugs, diets, supplies or equipment; weighing residents; taking vital signs and blood pressure.

(b) Indirect allocation of the therapeutic value of nursing presence, e.g., the restorative component of standards; nondirected or general conversations with the resident or the resident's family or friends; writing letters or placing telephone calls for the resident.

(c) Indirect allocation of nonproductive time (N-time), e.g., nursing conference time, vacation/sick leave time, coffee breaks and stand-by time.

(d) Indirect allocation of administrative/supervisory time, e.g., time required for staff training, consultant payments, and purchase of nursing services from "pools."

(E) Each unit or category within a standard has a predetermined value in terms of mean time necessary to render that service according to professional level of staff generally considered capable of rendering that service.

(1) These times encompass the same factors outlined in paragraphs (D)(1)(a) to (D)(1)(e) and (D)(2)(a) to (D)(2)(d) of this rule.

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